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Confidential Health Survey
(To be filled in by teenager)

Instructions: Completion of this form is voluntary. This questionnaire will help us get to know you better. Please answer the following questions and feel free to ask a staff member about items, which may be confusing to you.

Patient Name	Date of Birth	Today's Date
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What do you like to be called (nickname)?

Why are you coming to the clinic today?

On a scale of 1 to 10 how would you rate your general health? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Awful Great

Many teens and young adults have concerns about the following items. Check any box that may apply to you.

- | | |
|--|---|
| <input type="checkbox"/> trouble sleeping | <input type="checkbox"/> privacy |
| <input type="checkbox"/> being tired during the day | <input type="checkbox"/> friends |
| <input type="checkbox"/> headaches | <input type="checkbox"/> no friends |
| <input type="checkbox"/> stomach aches | <input type="checkbox"/> brothers / sisters |
| <input type="checkbox"/> dizzy / fainting spells | <input type="checkbox"/> parent / family |
| <input type="checkbox"/> height or weight | <input type="checkbox"/> grades / schools |
| <input type="checkbox"/> muscle or joint pain | <input type="checkbox"/> recurrent dreams or nightmares |
| <input type="checkbox"/> vision or hearing problems | <input type="checkbox"/> fear of unplanned pregnancy or STD's |
| <input type="checkbox"/> skin problems (acne, rashes) | <input type="checkbox"/> controlling your temper |
| <input type="checkbox"/> earaches | <input type="checkbox"/> nothing to do |
| <input type="checkbox"/> sore throats | <input type="checkbox"/> your future |
| <input type="checkbox"/> coughing or wheezing (asthma) | <input type="checkbox"/> feeling down or depressed |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> a place to live |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> family members drinking excess alcohol |
| <input type="checkbox"/> pain with urination | <input type="checkbox"/> using drugs |
| <input type="checkbox"/> allergies / hay fever | |
| <input type="checkbox"/> Other, describe _____ | |

Check all boxes that you would like to know more about.

- | | | |
|--|---|---|
| <input type="checkbox"/> menstruation | <input type="checkbox"/> AIDS or HIV exposure | <input type="checkbox"/> your sexual development / feelings |
| <input type="checkbox"/> pregnancy or having children | <input type="checkbox"/> teenage body changes | <input type="checkbox"/> masturbation |
| <input type="checkbox"/> birth control | <input type="checkbox"/> ways to deal with stress | <input type="checkbox"/> drugs / alcohol |
| <input type="checkbox"/> dating | <input type="checkbox"/> sexual assault or abuse | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sexually transmitted diseases (STD's) | <input type="checkbox"/> physical abuse | <input type="checkbox"/> death and dying |
| <input type="checkbox"/> Other, describe _____ | | |

Now think about these lifestyle patterns which may affect your health. Are there any you would like to change? If yes, check the appropriate boxes.

- | | |
|---|---|
| <input type="checkbox"/> nutrition or diet | <input type="checkbox"/> drinking alcohol or using drugs |
| <input type="checkbox"/> exercise | <input type="checkbox"/> getting along with family |
| <input type="checkbox"/> smoking / chewing tobacco | <input type="checkbox"/> sexuality |
| <input type="checkbox"/> sleep | <input type="checkbox"/> finding a job |
| <input type="checkbox"/> your response to stress | <input type="checkbox"/> communication with parents and others |
| <input type="checkbox"/> school performance | <input type="checkbox"/> use of seat belt / motorcycle / bike helmets |
| <input type="checkbox"/> making and keeping friends | |